Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	TN1935	A. BUILDING: **01 - MAIN BUILDING** B. WING_____	07/30/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE MEADOWS	**8044 COLEY DAVIS ROAD NASHVILLE, TN 37221**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N000	Initial Comments During the Fire Safety portion of the annual licensure survey conducted on 07/30/2018, no deficienices were cited under the Tennessee Department of Health, Board for Licensing health Care Facilities, Chapter 1200-08-06, Standard for Nursing Homes.	N 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: B. M. [signature] | TITLE: Administrator | (X6)DATE: 8/15/18